Expansion States Reap Results

Concerns Persist about Work Requirements for Coverage

JOHN MORRISSEY

Two single men, both struggling to get by, have contrasting prospects when seeking to safeguard their health with Medicaid coverage. One lives in Cleveland, makes $16,700 a year and receives the benefits of the government health program for the poor. The other, a Miami resident, brings in just $6,000 — half of what the federal government considers poverty-level income — but isn't eligible. He would easily qualify in Cleveland.

It's just one example of the stunning disparities that exist around the nation related to Medicaid, the safety net health care program that's funded by a combination of federal and state dollars. As of December 2018, 14 states hadn't expanded Medicaid under the Affordable Care Act. (The Affordable Care Act aimed to expand Medicaid nationally to provide more health care coverage; a U.S. Supreme Court ruling in 2012 made Medicaid expansion a state-by-state option.) Florida has opted not to expand Medicaid. Ohio was among states that went ahead with the expansion. Such policy decisions have real-world impact on who does and does not have Medicaid coverage.

Voters in three states passed mandatory ballot initiatives in the November 2018 election for their state governments to expand Medicaid. And the election of Democratic governors in two other states where incumbents had blocked expansion increased the likelihood that those states too would act to participate. A steady stream of information and analysis since 2012 showed that people in states that expanded Medicaid were healthier and less burdened financially by the cost of health care.

The split of states into "haves and have-nots" on the issue of Medicaid expansion created a rare opportunity to determine the impact of national health policy on portions of the nation that didn't enact it. "The way that the implementation of the ACA worked out, where some states opted not to expand Medicaid, has enabled pretty definitive research on the effects of expansion, or not expanding," said Rachel Garfield, Henry J. Kaiser Family Foundation (KFF) researcher and associate director of its program for Medicaid and the uninsured.

From a KFF analysis of more than 200 studies,[1] "we know that states that have adopted the expansion have bigger gains in coverage, larger reductions in the uninsured, higher increases in Medicaid enrollment compared with the states that haven't expanded," said Robin Rudowitz, also an associate director of the foundation's Medicaid research unit.

Health care systems concerned for the poor

and vulnerable had hoped to see just those kinds of results. "Catholic organizations lobbied and really advocated to have the expansion of Medicaid, and also to look at the health insurance exchanges and implement those, with the whole purpose being to have better access to care for the uninsured," said Cynthia Clemence, senior vice president at Trinity Health and chief financial officer of its operations. (Health insurance exchanges are marketplaces where individuals and small employers can purchase insurance plans.)

MEDICAID EXPANSION YIELDS RESULTS

Benefits to the poor abound. A range of studies has documented improved access to care and lower out-of-pocket costs for Medicaid enrollees in states with expanded eligibility. That improvement is compared with the lower levels of access and higher patient cost those same states reported before they expanded, as well as much better showings than current non-expansion states, Rudowitz said.

Those gains have translated into health care advancement often denied poor and uninsured people, such as improved ability to manage chronic illness and better access to mental health services. Medicaid also is associated with a greater likelihood of a "usual source of care," which is "a key indicator that shows whether someone is connected to the health care system, receiving regular, preventive services," said Garfield.

"There is a long body of evidence that goes back decades showing that health insurance coverage makes a big difference in your ability to access care when you need it," Garfield explained, "and so the research that looks at the effects of the Medicaid expansion is building on that, and reinforcing those findings."

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For instance, research shows that Medicaid enrollees are more likely to receive prescriptions for chronic conditions that can be managed with the right medications. People reported fewer unmet health care needs, that is, they were less likely to say that they have gone without care when it was needed, said Garfield. They reported a lower incidence of financial hardship when they do seek care.[2] Additionally, a January 2018 study found that for patients admitted with one of five common surgical conditions, expansion was associated with a significantly greater probability of receiving optimal care.[3] Another study of federally funded community health centers found that expansion was associated with improved quality in measures of asthma control, Pap testing, body mass index assessment and hypertension control.[4]

Expansion also has opened up access to behavioral health services, for which Medicaid has long been a payer/provider, said Rudowitz. Uninsured people usually did not have access to those services, but studies confirmed that such access increased in expansion states as part of the Medicaid benefit package.

Access to benefits that Medicaid covers is a big plus for people formerly uninsured, but including them formally in the Medicaid program also makes it more plausible for health care professionals to manage this population effectively. These individuals are now identified, located and insured instead of being out there on their own, and showing up for care only when medical problems arise. Now, physician offices and other health care providers can reach out to them about their health issues and are more apt to keep them stable, said Tina Grant, vice president of advocacy for Trinity Health.

If those patients seek treatment at an emergency department, care providers there are able to link the patient to additional care, such as a primary care provider who will accept the patient, conduct follow-up soon after an emergency department visit and get them into the patient-centered programs Trinity already has built for patients with Medicare or private insurance. These programs use patient care coordinators and other staff resources to monitor patient health status, anticipate problems before they get worse, and help patients find the most appropriate care provider to address those problems. "All that coordination that's happening in provider offices is now available to the expanded Medicaid population," Grant said.

COVERAGE GAPS REMAIN

Medicaid expansion through the Affordable Care Act did more than extend coverage to people earning up to 138 percent of the federal poverty level. It also filled in eligibility gaps in the traditional program. From Medicaid's outset in 1965, states had to offer an essential benefits package, but the states themselves determined who was poor enough to be eligible.

Several states including New York, Massachusetts and Minnesota already were at the upper income limit of the expansion when it became law. Regardless, those states all gained from participating because they were then able to cover childless adults, who have not been not included in traditional Medicaid at any income level.

Other states, particularly in the South, set their Medicaid eligibility far below the poverty level: 34 percent of poverty-level income in Georgia, 29 percent in Florida, 15 percent in Texas.[5] The low limits, combined with ineligible adults, made millions of people unable to access Medicaid going back decades, and in non-expansion states that coverage gap remains.

The KFF in a June 2018 issue brief calculated that 2.2 million Americans currently fall into that gap, more than 25 percent of them in Texas alone. Seventeen percent live in Florida and 11 percent in Georgia. That total does not include the millions more who would have been eligible with expanded Medicaid. In all, 4.2 million more uninsured adults in non-expansion states would be eligible if their states had opted for Medicaid expansion.[6]

HEALTH SYSTEMS SEEK IMPROVED REIMBURSEMENT

For hospitals, the greatly restricted eligibility in non-expansion states perpetuates the long-standing financial burden of caring for uninsured patients. The financial hit isn't due only to those who don't qualify for Medicaid but also due to skimpy payments for those who do qualify. Some states continue to impose severe limits on the percentage of costs they pay for Medicaid-insured services. Another financial challenge stems from the original negotiations surrounding passage of the ACA. Clemence said it's important to recognize the trade-off of "some very significant Medicare payment cuts in order for that legislation to be approved." The hospital industry accepted a lower reimbursement rate for Medicare amounting to $716 billion over 10 years. The ACA permanently trims the rate of growth in the prices that Medicare pays to hospitals and most other medical providers, a major source of paying for the act's programs. As a result, Medicare prices in 2021 will be about 11 percent lower than they would have been had the ACA not been enacted.[7]

In non-expansion states, hospitals still bear the burden of those Medicare cuts without being able to partially offset them by a drop in the number of uninsured and the relief from uncompensated care that follows. Even Trinity Health, whose hospitals in most of the states where it operates did benefit from expansion, has posted a $325 million net loss in its most recent fiscal year between what expansion giveth and Medicare taketh away. The shift from uninsured to Medicaid, along with movement into exchanges, resulted in $115 million less in uncompensated care, but lower Medicare reimbursements cost Trinity $440 million, Clemence said.

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CHRISTUS Health, based in Irving, Texas, has felt the strain from low Medicaid reimbursement rates and the decision not to expand Medicaid in that state. "I think we're probably the most glaring example of a non-expansion state," said Linda Townsend, system director for advocacy and public policy. "Not only did we not expand, but Texas has a Medicaid reimbursement rate roughly 51 percent of the actual cost of providing care."

CHRISTUS advocated for expansion, which succeeded for its hospitals based in New Mexico and Louisiana. In Texas, however, nearly 1.2 million people fell into the gap between the current low limits on Medicaid eligibility and where individual insurance bought through the ACA marketplace program took over for many middle-class Americans. And Texas hospitals still have to deal with the negotiated reduction in Medicare reimbursements, without getting any of the trade-off benefits in less uncompensated care, Townsend said.

Contrast that with Kentucky, where combined Medicaid expansion and ACA marketplace insurance resulted in 82 percent lower charity care costs and a 73 percent reduction in bad debt for KentuckyOne between fiscal 2013 and 2018, said Sherri Craig, division vice president for public policy for the health system, which is part of Catholic Health Initiatives. Total Medicaid patient mix increased by 206 percent while the proportion of self-pay patients decreased by 78 percent. Statewide, the uninsured rate dropped from 13.6 percent in 2012 to 6.1 percent in 2015 as 500,000 people were added to Medicaid after it expanded eligibility, Craig noted.

One national study of expansion states shows that uncompensated care fell from 3.9 percent of operating costs in 2013 to 2.3 percent in 2015, for an estimated savings across all hospital expansion states of $6.2 billion.[8] The largest reductions were found for hospitals that care for the highest proportion of low-income and uninsured patients.

One saving grace for non-expansion states was a slight bump in eligibility for traditional Medicaid among families poor enough to qualify but unaware of it until they found out from seeking marketplace-based insurance that they were Medicaid-eligible. And though the income limits may have been daunting for families, children in those families qualified for coverage based on the much higher household income eligibility levels of the Children's Health Insurance Program (CHIP), typically twice the federal poverty level, said Rudowitz.

PROBLEM OF WORK REQUIREMENTS

One cause for concern among critics of Medicaid expansion was that it might create a disincentive to work, that people with Medicaid coverage would not be motivated to get a job, even though that might allow them to gain private health coverage. Research has found little likelihood that expansion has been a disincentive to seeking work, and in many cases Medicaid coverage actually increases the odds of getting and keeping a job, Garfield reported.

Despite these findings, 15 states either have gained a waiver or are considering seeking one to tie Medicaid eligibility to proof of employment on the premise that able-bodied recipients shouldn't be allowed to take the benefit and not seek work. The ultimate effect of such initiatives may be to kick eligible people off the Medicaid rolls. In fact, Garfield warned, a significant number of working people risk losing Medicaid because of the administrative barriers involved in reporting their employment status. According to a KFF issue brief, published in June of 2018 on implications of work requirements, 6 in 10 Medicaid recipients already were working, and of those not working, all but 6 to 7 percent were exempted because they had a health condition or disability, a caretaker role or were parent to a young child. An analysis of the effect of work reporting requirements on coverage found that most of the estimated number of people who could lose coverage were already working or exempt, not idly unemployed — because of the complications of duly reporting their status.[9]

In September 2018, 4,353 poor residents in Arkansas became the first in the nation to be dropped from Medicaid for not meeting work requirements. It's a state where nearly 25 percent of its population live in areas without internet service — and work updates have to be reported online. Critics said people lost eligibility from failure to satisfy the administrative process. Kentucky had been ready to implement its waiver program on July 1, but a federal court ruled the work requirements invalid because the state didn't consider the plan's impact on low-income populations identified in the original Medicaid statute.

Removing working people from Medicaid coverage ironically runs counter to a positive factor for employment: that enrolling in Medicaid improves the job outlook. An Ohio analysis of expansion enrollees who were unemployed but looking for work reported that Medicaid enrollment made that objective easier, and more than half of employed expansion enrollees found it easier to continue working.[10] The expansion also allowed people clinging to Medicaid coverage based on disability to qualify instead based on income, which increased their motivation to look for work if and when they were able.[11] Qualifying for disability is better than no Medicaid coverage where income limits are very low, but it requires that the person can't work, even if motivated to find a viable job. "When people can qualify just based on income and don't have to meet that stringent disability criteria — they don't have to demonstrate that they're not able to engage in work — they are more likely to be able to participate in the work force," Garfield explained.

MOVING FORWARD

Medicaid today has demonstrated its value in states that opted to expand it under the ACA, but it has had unintended consequences for hospitals in some circumstances in addition to the Medicare hit. For example, it has the tendency to reduce revenue volume from commercial payers where working people with employer coverage find it to their advantage to switch to Medicaid.

CHRISTUS Health's hospitals in Louisiana suffered those revenue losses when the state joined the expansion early in 2016 after a change in governors, said Townsend. A population of workers with commercial coverage, but with sizable premiums and out-of-pocket share of medical bills, dropped employer coverage for the less costly Medicaid coverage after they became newly eligible. The net impact to hospitals, Townsend said, was a lower reimbursement rate than if the Medicaid-eligible had stayed on commercial plans.

For the nation's insured population, the problem of affordability remains despite the inroads made by the implementation of the ACA. Though the percentage of non-elderly population still uninsured is the lowest ever recorded, at just under 11 percent, another 15.5 percent who have insurance either skipped or delayed care because of problems paying the bill in 2017, said Drew Altman, KFF president and CEO, in a column on the online news site Axios in August 2018.[12] That puts the percentage with affordability problems at 26 percent.

That rings true in Kentucky, where 31 percent of its population of 4.45 million are on Medicaid after the expansion, said Craig of KentuckyOne Health. Even with the increase in insured people, 1 in 4 Kentuckians remain underinsured and challenged by out-of-pocket costs, she said. Stakes get higher as negotiations continue among the federal government, the Kentucky governor's office and health care interests such as hospitals to reach an acceptable compromise on the work waiver initiative, said Craig. "In a state with high poverty and poor health, we still have a lot of opportunity for improvement for sure."

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NOTES

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